ARIZONA DEPARTMENT OF HEALTH SERVICES

ASSISTED LIVING LICENSING

Adult Day Health Care Facility
Adult Foster Care
Assisted Living Center
Assisted Living Home
Unclassified Health Care Institution

Renewal Application Packet

<u>Includes</u>:

1. **Instructions for completing Health Care Institution Application**
2. **Renewal Application for Health Care Institution License**
3. **Application Supplement (Except Adult Day Health Care Facility & Unclassified Health Care Institution)**
4. **Health Care Institution Renewal and License Fee Remittance Form (Exempt for Adult Foster Care)**

Submit the completed Application Packet including the following:

- ❑ Application with signed and notarized signature(s)
- ❑ Application Supplement
- ❑ Renewal and License Fee Remittance Form
- ❑ Application and Licensing Fees, NON-REFUNDABLE (NO PERSONAL CHECKS)

<u>PLEASE RETURN COMPLETE APPLICATION PACKET WITH BUSINESS CHECK, CASHIER'S CHECK OR MONEY ORDER TO</u>: MAKE PAYABLE TO – ARIZONA DEPARTMENT OF HEALTH SERVICES

____150 North 18th Avenue, Suite 420 - Phoenix, Arizona 85007
____ 400 West Congress, Suite 116 - Tucson, Arizona 85701

Instructions for completing HCI Application

PLEASE TYPE OR PRINT IN BLACK INK**.**
Please submit the application, with all required attachments and the required fee. This application will not be complete until all required attachments and fees have been submitted to the Department. If any corrections are made to the application using correction fluid or correction tape, the application will be returned. If you make a mistake filling out the application, put a line through the mistake and initial.

I. HEALTH CARE INSTITUTION INFORMATION

Provide all required information.

"Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Services. (If you are using an individual's Social Security Number, it will be treated as confidential information and redacted from the copy of the application in the facility's public file.)

According to Arizona Revised Statutes, Title 36, Chapter 4, or Arizona Administrative Code, Title 9, Chapter 10, a person may apply for a license as a **health care institution class or subclass**, which are listed below**. Select one of the following classifications and write it on the application**.

Adult day health care facility,
Adult foster care,
Assisted living center,
Assisted living home or
Unclassified Health Care Institution.

II. OWNER INFORMATION

"Owner" means a person who appoints, elects, or otherwise designates a health care institution's governing authority. "Proprietary" means an owner or owners. "Non-Proprietary means a leased business, franchise, or in certain instances, a Governmental Agency.

III. GOVERNING AUTHORITY

"Governing authority" means the individual, agency, group or corporation, appointed, elected or otherwise designated, in which the ultimate responsibility and authority for the conduct of the health care institution are vested.

IV. CHIEF ADMINISTRATIVE OFFICER

"Chief administrative officer" means the individual implementing a governing authority's direction in a health care institution. This is the on-site administrator, or the certified manager.

V. SIGNATURES - A.A.C. R9-10-105(A) REQUIRES THE APPLICATION SIGNATURES TO BE NOTARIZED

According to A.R.S. § 36-422(B) the application **must be signed**, as follows:

(1) If an individual, by the owner of the institution;
(2) If a partnership or corporation, by two of the partners or corporate officers; or
(3) If a governmental unit, the head of the governmental department having jurisdiction.

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES

150 North 18th Avenue, Suite 420 •• Phoenix, Arizona 85007
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RENEWAL APPLICATION FOR A HEALTH CARE INSTITUTION LICENSE

A.R.S. Title 36, Chapter 4 and A.A.C. Title 9

I. HEALTH CARE INSTITUTION INFORMATION

Name of health care institution		License number
Mailing address		
City	State	Zip code
Telephone number	Fax number	E-mail address
Health care institution class or subclass:		

II. OWNER INFORMATION

Owner's name		
Address		
City		Zip code
Telephone number		Fax number
The owner is a: (check one)	_____Proprietary	_____Non-proprietary
The owner is a: (check one)	_____Sole proprietorship	_____Partnership
_____Limited liability company	_____Corporation	_____Governmental Agency

A. PLEASE LIST IN THE SPACE PROVIDED BELOW:
If the owner is a partnership, the name of each partner;
If the owner is a limited liability company, the name of the designated manager, or if no manager is designated, the names of any 2 members of the limited liability company;
If the owner is a corporation, the name and title of each corporate officer; or
If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the individual designated in writing by the individual in charge of the governmental agency.

Name	Title
Name	Title
Name	Title
Name	Title

B. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a license to operate a health care institution denied, revoked or suspended since the last application was submitted?
____Yes ____ No.

C. Has the person applying for a license or a person with 10% or more business interest in the health care institution had a health care professional license or certificate denied, revoked or suspended since the last application was submitted?
____Yes ____ No.

D. If either of the previous questions is answered yes, include on a separate sheet of paper for each yes answer:
1. The reason for the denial, suspension, or revocation;
2. The date of the denial, suspension, or revocation;

3. The name and address of the licensing agency that denied, suspended, or revoked the license.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone number

III. GOVERNING AUTHORITY

Name

IV. CHIEF ADMINISTRATIVE OFFICER

Name	Title
Education (list the highest educational degree obtained and any instruction related to the health care institution class or subclass for which licensure is requested)	
Experience (list work experience related to the health care institution class or subclass for which licensure is requested)	

V. SIGNATURES

According to A.R.S. § 36-422(B) the application must be signed, as follows:

(1) If an individual, by the owner of the institution;
(2) If a partnership or corporation, by two of the partners or corporate officers; or
(3) If a governmental unit, the head of the governmental department having jurisdiction.

A.A.C. R9-10-105(A) requires the application signatures to be notarized.

_____ _____
Signature Date

_____
Title

STATE OF_____)

COUNTY OF _____)

Subscribed and sworn to before me this

_____ day of _____,_____

by_____
Notary Public

My Commission Expires_____

_____ _____
Signature Date

_____
Title

STATE OF_____)

COUNTY OF _____)

Subscribed and sworn to before me this

_____ day of _____,_____

by_____
Notary Public

My Commission Expires_____

For DHS use only: Correct application fee enclosed: _____ Yes _____ No Check #:

APPLICATION SUPPLEMENT

Assisted Living Licensing

I. Level of Care:

Directed _____

Personal _____

Supervisory _____

II. Total Capacity of Facility: _____

III. Name of Certified Manager:_____

Certified Manager's Number:_____

_____
Signature of Administrator

_____
Signature Date

Please complete this form and return with your application.

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of Licensing Services
Assisted Living Licensing
150 North 18th Avenue, Suite 420, Phoenix, Arizona 85007 ● (602) 364-2536
400 West Congress, Suite 116 – Tucson, Arizona 85701 ● (520) 628-6965

HEALTH CARE INSTITUTION RENEWAL APPLICATION AND LICENSE FEE REMITTANCE FORM

PLEASE RETURN THIS FORM WITH THE PAYMENT TO THE ADDRESS ABOVE

FACILITY I.D. #:	**LICENSE #:**	**LEVEL OF CARE OR SERVICES**		
APPLICANT/ENTITY NAME:				
FACILITY NAME:				
STREET ADDRESS:		**SUITE #:**		
CITY:		**STATE:**	**ZIP:**	
PHYSICAL ADDRESS:				
CITY:		**STATE:**	**ZIP:**	

FEES	**AMOUNT DUE**
Application Fee (Please do not submit the application fee if the fee has already been paid.)	$ 50.00
LICENSED CAPACITY	

Check One:	Licensed Capacity:	Base Fee:	Number of Beds x $10.00 each:	Total base fee plus number of beds fee:
	None	$ 100.00		
	1 to 59 beds	100.00		
	60 to 99 beds	200.00		
	100 to 149 beds	300.00		
	150 or more beds	500.00		

TOTAL AMOUNT DUE	$

Payment should be by cashier's check, money order or business check made payable to:
ARIZONA DEPARTMENT OF HEALTH SERVICES

Write the Facility I.D. # or License # on the check.
Cash and personal checks are not accepted.

AMOUNT ENCLOSED	$

ALL FEES ARE NON-REFUNDABLE pursuant to A.R.S. § 36-405(c), 36-882(f) and 36-897.01(c), except as provided in A.R.S. § 41-1077.